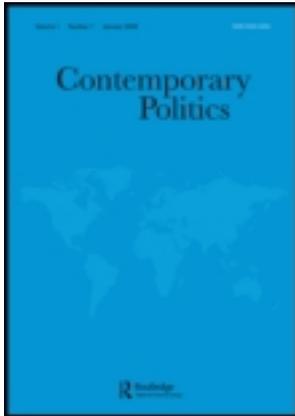


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### Descriptive representation and AIDS policy in South Africa

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## Descriptive representation and AIDS policy in South Africa

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The global AIDS pandemic raises key questions with respect to Pitkin's seminal concerns for the descriptive and substantive representation of diverse citizen interests. Specifically, are there 'group interests' for AIDS-related policies, and are they represented by political leaders? One might expect *all* politicians to prioritize a response to the global pandemic as a matter of public interest, especially in high prevalence countries. Alternatively, because recognizable sub-groups are affected differently, theories of representation imply that leader preferences should vary along these lines. The author explores the local political representation of AIDS-related interests within the context of the high prevalence, heterogeneous, and democratic society of South Africa. Through analysis of an original survey of the attitudes and preferences of local councillors in Eastern Cape Province, he found that descriptive representation is associated with substantive representation: politicians express AIDS policy preferences in accordance with race- and gender-based interests, albeit in different ways.

**Keywords:** AIDS; policy-making; race; gender; representation

### Introduction

To date, most accounts of individual political leaders responding to the AIDS pandemic have tended toward one of two extremes: on the one hand, analysts working closely within AIDS policy circles have offered more voluntaristic accounts that emphasize the personal acumen or 'political will' of individual leaders.<sup>1</sup> For example, in a discussion of the early global governance response to HIV/AIDS, Merson (2006) explained, 'Despite its achievements, the Global Program on AIDS was unable to muster the necessary *political will* in donor and affected countries'; and Raviglione and Smith (2007), in the discussion of a tuberculosis (TB) control program, stated, 'These measures ultimately require political commitment and will, and in many countries, health is still not a top priority'. In a similar manner, when discussing the prospects for implementing highly active antiretroviral therapy in resource-poor settings, Farmer *et al.* (2001, p. 408) argued, 'These innovations require *political will* at high government levels'. Some analysts have tended to focus on the seemingly pathological former South African President Thabo Mbeki and his selected health ministers (Nattrass 2007) as examples of the autonomy of individual leaders.

On the other hand, political scientists and other social scientists studying the determinants of AIDS-related policies have tended toward the opposite end of the continuum, virtually dismissing the role of individual politicians and focusing instead on the structural and institutional pressures that shape policy-making. Such studies have argued that the content of policies can be predicted from a range of factors, such as level of economic development, HIV prevalence, levels of foreign funding, electoral cycles, patterns of ethnic relations, and other variables

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(e.g. Fourie 2006, Gauri and Lieberman 2006, Patterson 2006, Bor 2007, Strand 2007, Youde 2007, Lieberman 2009, Dionne 2011).

In this article, I explore a middle ground. I focus explicitly on the preferences of individual politicians, but I consider the factors that might help to explain why their views about AIDS policy vary even within the same institutional and structural contexts. Specifically, I consider their role as democratic *representatives*, which casts them in a quite different light from one in which they are described as isolated agents who may or may not possess ‘political will’.

Particularly in diverse societies, Pitkin’s (1967) notion of descriptive representation (p. 89) – the mirroring of the characteristics of the community within the representative body – is consequential because people tend to assume that those characteristics are good guides to the actions politicians will take in office. Importantly, however, she raises the question of whether in practice this leads to ‘substantive’ representation, or the actual representation of the diverse interests of the community. In numerous studies of the attitudes and behaviours of elected representatives in advanced industrialized countries, scholars have found evidence of substantive representation in legislative priorities according to individual characteristics such as race and gender. In a provocatively titled account of descriptive representation – ‘Should blacks represent blacks and women represent women? A contingent “yes”’ – Mansbridge (1999) argues that particularly for ‘uncrystallized issues’, the best representation may come from descriptive representatives.

To my knowledge no research has been conducted on the quality of representation for the problems of HIV, AIDS, or the closely associated TB epidemic.<sup>2</sup> These are leading causes of mortality and morbidity around the world, particularly in sub-Saharan Africa, and given the scope of the problems, they have not been considered along with more obviously distributive or targeted policy issues that are often the objects of analysis within studies of descriptive representation. Optimistically, one might like to think that major global public health issues would transcend ‘group’ interests. In other words, perhaps both citizens’ and politicians’ views about global public health and the health of their communities are shaped not by differences in terms of specific groups, but in terms of shared societal or even global concerns and priorities. If the latter were true, individual characteristics would not predict policy preferences. But in the complex reality of politics, citizens face many competing problems, and the threat of infectious disease clearly affects some groups of citizens more intensely than others. The question posed here is whether politicians themselves actually represent those views according to their own group characteristics, or if they simply reflect on the problems that face their constituencies, irrespective of group affiliations?

In this article, I focus explicitly on politicians. Specifically, I assess whether individual race and gender identities help to predict the infectious disease policy preferences of local politicians in the Eastern Cape Province of South Africa, potentially providing substantive representation of their own groups. As I discuss later, local councillors provide an outstanding target for investigation, because they tend to live and work within close proximity to one another, facing the same local communities, and yet within diverse societies, they may be associated with different population sub-groups. Moreover, because local councillors are called upon to be local problem solvers on a daily basis, their individual preferences and priorities are easily turned into action, in many ways unmediated by legislative or other institutions.

In the next section, I explain why citizens might have different intrinsic interests with respect to HIV and AIDS that vary along both race and gender lines, motivating an examination of whether such interests are differentially represented by local politicians. Subsequently, I describe the collection of data through an original survey of local councillors, and present the main findings from various analyses of those data. I conclude by highlighting the theoretical and policy implications of this study. As a preview, I find that both race and gender *are*

substantively represented by local cancellors, but in different ways, which ultimately cast a mixed light on the value of descriptive representation in this arena for the particular concerns of HIV, AIDS, and TB control.

### Gender, race, and AIDS

Individual politicians, like individual citizens, can be described in terms of a virtually limitless number of personal characteristics, but as Pitkin (1967) notes, the notion of descriptive representation makes sense only in the context of politically relevant characteristics. In the context of AIDS in South Africa (the motivation for the choice of this location for study is discussed in the next section), the characteristics of both gender and race clearly merit investigation. Scholars studying descriptive representation in the USA and Europe have focused almost exclusively on these dimensions. And in South Africa, not only are these generally salient categories, but strong race- and gender-based political organizations have a longstanding history in the country: South Africa's history of institutionalized white supremacy is well known; moreover, women have routinely formed their own political organizations, such as the African National Congress (ANC) Women's league; and the Black Sash, a human rights organization founded by women to help other women and to protest the apartheid system of government.

Moreover, HIV prevalence varies substantially across gender and race lines within the country. The most authoritative survey of HIV prevalence finds that levels are much higher among women than men, particularly in the 25–29 age group, in which 32.7% of women were HIV-positive, as compared with male HIV prevalence of 15.7%. Nationwide, HIV prevalence for women was 13.6% and for men 7.9% (Shisana *et al.* 2009, p. 79). Starting in the early 1990s, scholars began writing about differential AIDS risk for women, and gender-targeted prevention strategies (e.g. de Bruyn 1992, Heise and Elias 1995) in developing countries, especially in Africa. In the specific case of South Africa, Albertyn (2003) argues that the AIDS epidemic has posed a distinctive threat to the prospects for gender equality. While there is no documented evidence of similar gender-based discrepancies in terms of TB prevalence, other factors, including the association of pregnancy with disease vulnerability (Bates *et al.* 2004, p. 268), contribute to the perception that TB also affects women disproportionately.

In other contexts, gender has been found to be an important predictor of politician preferences for particular public policies. For example, Poggione (2004) finds that female US state legislators are more liberal in their views on welfare policy; and in a study of village councils in West Bengal and Rajasthan states in India, Chattopadhyay and Duflo (2004) find that the gender composition of councils affected the types of public goods provided, specifically in line with gender-based preferences. In an analysis of the self-reported activities of 322 legislators in 12 American states, Thomas and Welch (1991) find that female state legislators were more attentive to women and family planning issues. And in a survey of Latin American legislators, Schwindt-Bayer (2006) finds substantial gender differences in attitudes toward women and children/family issues.

Drawing on these studies, it is reasonable to predict that in the case of HIV, AIDS, and perhaps to a lesser extent, TB, women might be more likely to perceive associated risks of and to express preferences for policies that target these diseases.

Similarly, race or ethnicity emerges in other contexts as an important determinant of policy preferences and priorities, and in racially divided societies (such as the USA), one would certainly be tempted to predict racially distinctive politician attitudes and behaviour. In a study of American legislators, Barrett (1995) finds distinctive race- and gender-based preferences for a range of policy issues. Particularly in the case of a stigmatized condition such as HIV, risk may be widely discussed in ethnic or racial terms (Cohen 1999, Lieberman 2009). In

South Africa, by 2008, 13.6% of Africans were HIV-positive, as compared with just 0.3% of whites and 1.7% of coloureds (Shisana *et al.* 2009, p. 79). Of course, in the South African context, the racial minorities (whites and coloureds) were previously advantaged politically, and still enjoy better socio-economic circumstances, so the normative implications of distributive and substantive representation are different than if those groups had been disadvantaged minorities. And yet, one of the cornerstone rationales for the value of descriptive representation is more diffuse legitimacy within the population, which itself is intrinsically valuable (Mansbridge 1999, p. 634).

Nonetheless, we should not always assume that gender or race will be robust predictors of policy preferences. As suggested, in the face of a substantial crisis, perhaps all leaders, irrespective of group characteristics, would perceive and prioritize objective dangers in the same way. Moreover, among women and among Africans, increasingly diverse socio-economic circumstances might dilute any sense of common interests: a wealthy, highly educated African male might have tastes more similar to that of a similarly wealthy and educated white woman than another African man who did not attend secondary school and lives in a shack. In short, one should not take for granted the primacy of any particular characteristic as a predictor of social salience (Connell 1987, Cornell and Hartman 1997), let alone policy preferences. Moreover, if one looks at the policy behaviour of three of South Africa's recent health ministers – Manto Tshabalala-Msimang (an African woman), Barbara Hogan (a white woman), and Aaron Motsoaledi (an African man) – experiences do not conform to theoretical expectations. Based on the discussion above, one should have expected the most aggressive response to AIDS from Tshabalala-Msimang, but without doubt, the opposite was true, as she helped lead a period of extreme AIDS denialism (Nattrass 2007). That said, it would be a mistake to generate inferences from just three politicians, who each emerged in very different political contexts and moments in history. A better approach is to engage in more systematic comparisons, to which I turn in the next section.

### Research design

Do politicians with different group characteristics respond to similar circumstances in different ways? This is largely a descriptive question, and future research will need to more thoroughly examine causal pathways, as discussed in the conclusion. I seek to understand the extent of substantive representation for AIDS and TB by exploring the extent to which policy preferences and perceptions vary systematically in terms of group characteristics.

Along these lines, I chose to investigate *local* politicians for three key reasons. First, in recent years, local governments have been assigned increasing responsibility for service functions, including in the HIV sector, and yet to date, most research on the politics of policy-making has been at the national level. With just a few exceptions (e.g. Kelly and Van Donk 2009, Dionne 2010), local-level politicians have been under-studied in analyses of the response to HIV and this work helps to address that gap. Second, local politicians are useful to study for an analysis of policy preferences because within a relatively small area, a potentially large number of such politicians, at equal rank, and facing similar economic, political, and epidemiological conditions, can be studied systematically. This allows us to assess the effects of both constituency and individual characteristics. Third, local politicians tend to be easier to access than national politicians, who for various reasons tend to be less willing to complete the types of surveys routinely used to study policy preferences, such as the one used in this study.

I chose to study South Africa for several reasons, including the quite substantial prevalence of infectious diseases in that country, and increasing degree of policy decentralization – including in the area of HIV – which makes local councillors an appropriate subject of investigation.

The country's history of heterodox AIDS policy responses in the wake of high HIV prevalence (Schneider 2002, Gauri and Lieberman 2006, Nattrass 2007) suggested that it might be a fruitful place to explore variation in policy preferences. The Eastern Cape was identified as a useful site for study as a diverse province – economically, racially, and in terms of local capacity. In terms of most human development indicators, it generally ranks in the middle of the nine South African Provinces. In 2008, HIV prevalence in the Eastern Cape was estimated at 9.0% for all persons, slightly lower than the national prevalence of 10.9% (Shisana *et al.* 2009, pp. xvi, 79).

The central source of data for the analyses presented below is an original survey of municipal local councillors. While it is certainly true that much policy-making takes place in the offices of line ministries, such as departments of health, the motivation of the study was to better understand politicians who could plausibly address a very full range of problems. The initiative to focus on or prioritize a particular problem, such as AIDS or a related infectious disease, is truly meaningful only when a politician could plausibly address or choose to ignore that problem. That is, it would not be very interesting if the head of an AIDS commission said that AIDS was a priority. Along these lines, local councillors are routinely called upon to help solve the myriad problems that citizens confront in their daily lives. Moreover, local councillors are more than just legislators – they act as community leaders, assisting in the development of local programs and encouraging partnerships and constituent activities. Their own preferences are likely to mediate the implementation of government policies on the ground because they are likely to spend their time and political capital focused on priority issues, particularly as articulated by their political parties.

I employed a set of research assistants, including two American graduate students and three American undergraduates, along with two South African graduate students and one undergraduate. In total, three of the eight team members were male, and among the South Africans, two were black African, and native speakers of Xhosa, and the third was white and a native speaker of Afrikaans, but all three spoke fluent English. Because issues of race and language are politically sensitive in South Africa, our ability to form a team that contained a diverse membership provided good access to respondents.<sup>3</sup> We fielded a pen-and-paper survey of the attitudes and opinions of municipal councillors that could be completed relatively quickly (in approximately 15 min). The survey questionnaire was developed in English, translated into the other local languages, Xhosa, and Afrikaans, back-translated into English, corrected and repeated until we were certain that the measurement instrument was consistent across languages.

The survey was fielded during the period June–August 2009. For each municipality, we began by contacting the speaker of the local council and requesting permission to distribute the survey to councillors. We worked with the individual councils to identify the most effective strategy for distributing and retrieving the responses. Sometimes, councillors filled out the survey prior to the start of a meeting, and at other times, they did this on their own time, within days of the survey being delivered to the council office. The councillors returned the completed surveys to the secretary of the Speaker, who then forwarded the surveys to us. We provided a small, cash compensation to administrators in the speakers' offices for the extra work involved, and as an incentive for completing it, we told councillors that all completed surveys would be entered in a lottery for a R1000 postal check cash prize, and this was paid to two councillors at the conclusion of the survey.

We collected responses from 166 local councillors across 11 municipalities in Cacadu and Amathole districts, and in the Nelson Mandela Metropolitan municipality. We achieved a response rate of 42.1% overall, and on average, 56.6% of councillors in each municipality responded. Substantial political turmoil involving the recall of several top officials in Buffalo City Municipality during the summer of 2009 impeded the successful fielding of that survey. To a lesser extent, we also faced problems in Nelson Mandela – because we contacted the speaker of the council to obtain permission to field the survey, we learned that some councillors

feared the motivation of the survey was a test of ‘political alliances’. Party in-fighting and protests shut down the municipal government in Sunday’s River Valley which adversely affected the response rate. These issues notwithstanding, as discussed below, we attained a relatively representative sample relative in terms of the salient characteristics of the population.

**The measurement and distribution of councillor policy preferences**

Local councillor attitudes and policy preferences with respect to HIV, AIDS, and TB were measured along three dimensions: risk perception; policy prioritization; and support for specific policy proposals. When considering their responses, it is important to recall that councillors were not aware of our specific interest in HIV, AIDS, or infectious disease, and the survey asked questions about a wide range of topics that would be of concern to local governments. Councillors were told that the motivation for the study was an interest in the functioning of local democracy in South Africa, and the title on the survey form was, *Democracy in South Africa: Local Councillor Questionnaire*.

The distributions of responses are depicted in Figures 1–3. I measured risk perception by asking respondents to, ‘Please rate the following risks in terms of how much they affect people...’. On a table that listed 16 different risks, they were asked to rate each one on a point scale as follows: 1, no risk; 2, minor risk; 3, moderate risk; 4, major risk; 5, extreme risk. Of all the risks considered, HIV was rated the most severe risk, with the mean response being 4.36 among councillors; theft and alcohol or drug abuse came second and third, with risk ratings of 4.13 and 4.08, followed by TB risk, which was rated 3.95. A full 88.9% of respondents rated the risk of HIV as being major or extreme, and 72.5% so rated the risk of TB. Thus,

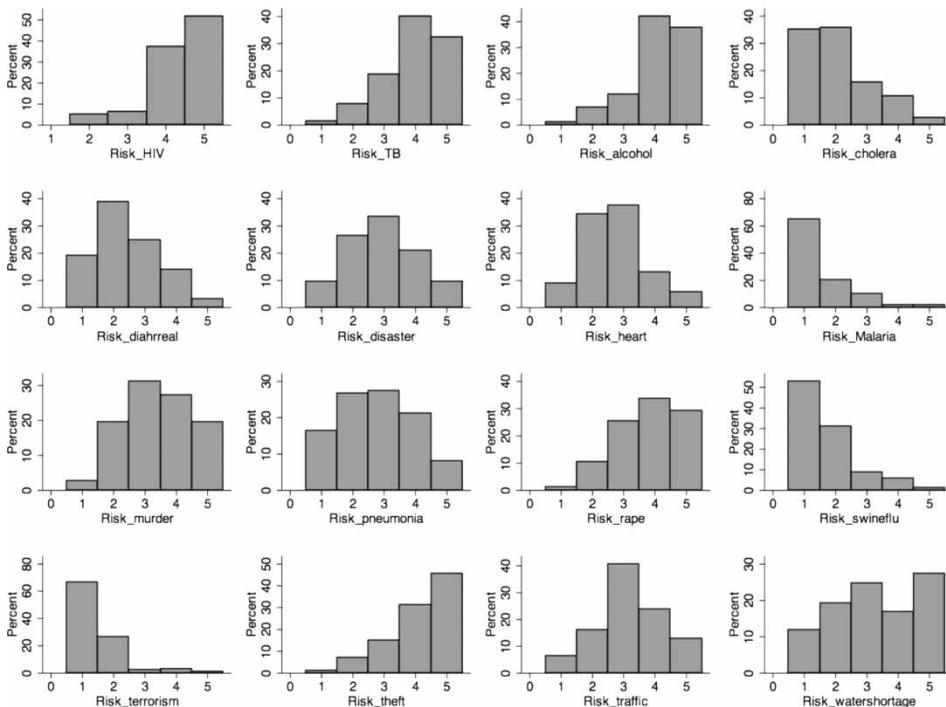


Figure 1. Distribution of councillor risk perceptions.

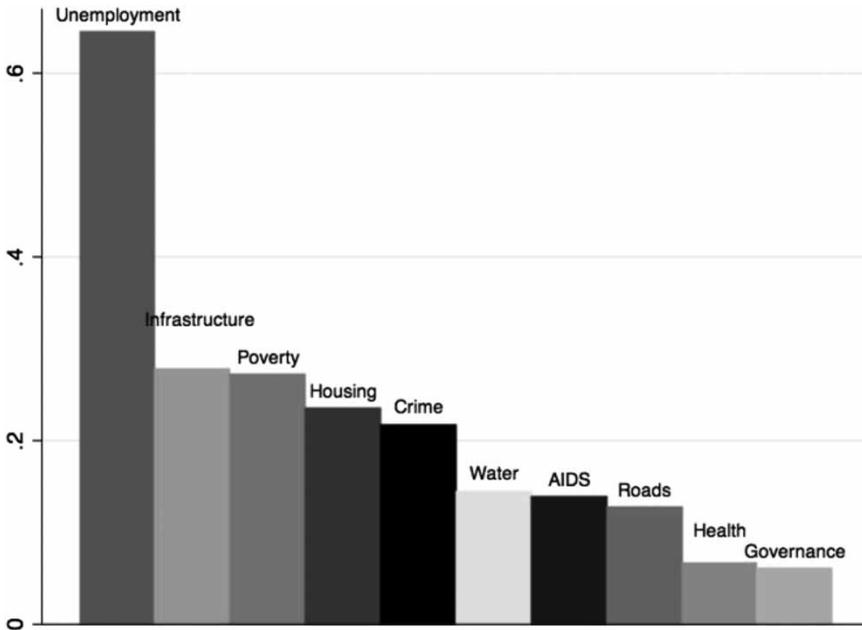


Figure 2. Councillor prioritization of AIDS as a leading problem.

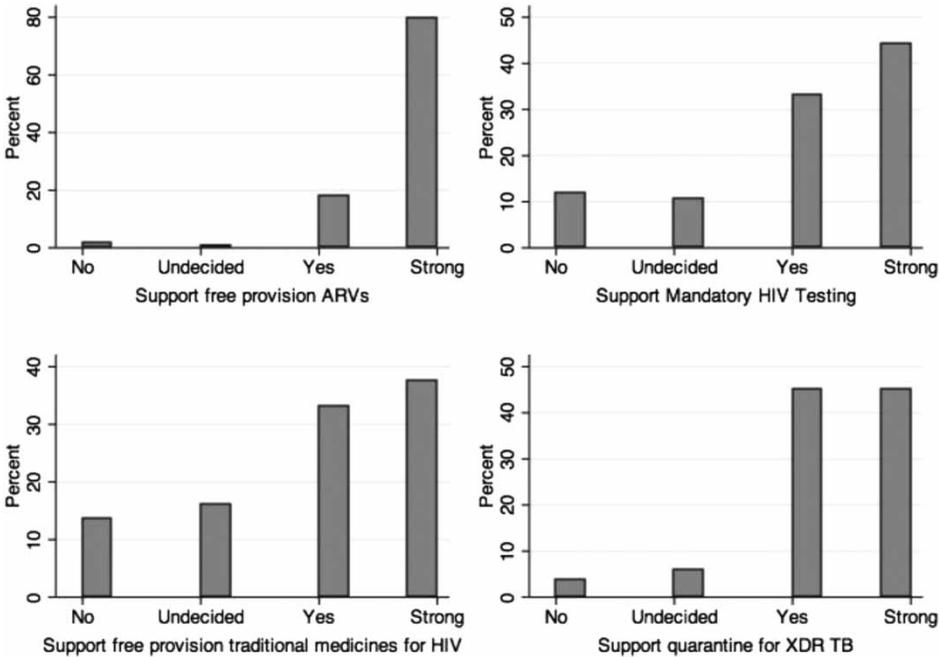


Figure 3. Councillor support for specific policies.

there was a relatively small degree of variation in risk perception, and certainly not to the degree one would have expected if I had carried out the survey earlier in the epidemic.

In order to measure policy prioritization, the survey began with an open-ended question, asking councillors, ‘What are the three most important problems that you believe face people

living in this municipality?' If they mentioned HIV or AIDS in any of their responses, I classified a dummy variable for AIDS prioritization as one; otherwise, it was coded zero. Only 13.9% mentioned HIV or AIDS as a priority, making it the seventh most mentioned priority among the councillors in our survey, following unemployment (64.5%), infrastructure (27.7%), poverty (27.1%), housing (23.5%), crime (21.7%), and water (14.5%). It is particularly interesting that although councillors, on average, rated the risk of HIV to be more severe than crime, the proportion of councillors identifying crime as a priority was more than 50% greater than the proportion that identified HIV or AIDS. The councillors surveyed generally represented poor municipalities and poor wards, and the issues surrounding poverty, security and basic services clearly took priority when compared with HIV and AIDS. And despite being a leading killer in a high prevalence area, TB was identified by just three councillors, making it one of the lowest expressed priorities. In light of the consensus around the high risk of being affected by HIV, AIDS, and TB, the relatively low prioritization as a policy issue is striking.

Along these lines, it is also important to highlight that councillors in our survey assigned a slightly lower priority to AIDS than citizens did more generally. On the 2008 round of the Afrobarometer survey, 21.1% of all respondents; and 16.7% of those from the Eastern Cape Province identified AIDS as one of the top three problems. However, it should be mentioned that the question wording was different – 'In your opinion, what are the most important problems facing this *country* that government should address?' Moreover, given that ours was not a representative sample of Eastern Cape councillors, and our respondents were from lower prevalence areas of the Eastern Cape, there is good reason to believe that overall, a similar share of local councillors identified AIDS as a priority that would have been found in an otherwise identical survey of citizens.

Finally, the survey asked questions about support for specific infectious disease-related public policies posed in terms of a list of other options. Specifically, the question asked, 'Which of the following policies and proposals do you support for *government action*? Please consider the likely costs and tradeoffs associated with any proposal. (Place an X in the column that best reflects your views.) The government should. . .' and for each policy proposal, the respondent was presented with a Likert scale, and could indicate one of four choices: No I do not support; I am undecided; Yes, I support; Yes, I strongly support.

The survey asked councillors to comment on four relevant policies: provide free antiretroviral (ARV) drugs to people who are HIV-positive; make HIV testing mandatory for everyone; provide free traditional remedies (like herbs or special foods) to people who are HIV-positive; and quarantine people with extremely multi-drug-resistant forms of TB (XDR TB). As shown in Figure 3, there was overwhelming support for the free provision of ARV's with 79.6% strongly supporting and another 17.9% supporting. While a large majority of respondents still supported the other three policies, there was less consensus around strong support, and the latter better indicates a willingness to take a leadership or aggressive role in promoting a particular policy. For mandatory testing, 44.4% strongly supported and 33.1% supported; for traditional medicines 37.4% strongly supported and 33.1% supported; and for XDR TB quarantines, 45.2% strongly supported and an additional 45.2% merely supported the proposal.

In the remainder of this article, I focus on exploring the determinants of variation in councillor attitudes and preferences, but it is worth reflecting on some of the key commonalities. To a large extent, the vast majority of local councillors *did* perceive a substantial risk from HIV, and agreed on several critical modalities for prevention and treatment. In a democratic context, one could imagine some conflicts over who benefits from public health spending, but when it comes to the free provision of ARV drugs, for example, this was not the case. Despite this, the vast majority of local councillors did not identify AIDS as one of their 'top priorities'. While

Dionne (2010) found similarly low levels of prioritization among village headmen in Malawi, in South Africa, infection levels are significantly higher, and general socio-economic conditions and infrastructure are better. Notwithstanding, local leaders, like citizens, placed many other basic needs higher on their lists of priorities. This is not necessarily a bad thing from the perspective of addressing the problems of infectious disease – for instance, better housing might reduce the transmission of TB; better job opportunities might reduce the extent of transactional sex that can lead to increased vulnerability to HIV transmission. But interested observers should be realistic about where AIDS stands in the hierarchy of quotidian concerns.

**The characteristics of local councillors**

In order to study the extent of substantive gender and race representation, I focus on the self-reported characteristics of the local councillors. Of particular interest, on both dimensions, I find an extremely high degree of descriptive representation, which is to say that the race and gender composition of the councillors in our sample comes quite close to mirroring the relative shares of groups within the population in those areas. (In Figure 4, I depict the relative distribution of the councillors in the survey sample in terms of race and gender.)

Although there are no specific enforcement mechanisms for the representation of women in the South African constitution, political parties have actively sought to attain gender parity, and have been increasingly successful in this regard since the 1994 elections (EISA 2009). In our sample, a full 53% of the respondents were female, which is exactly the share of female citizens counted in the 2001 census for the municipalities included in the study (author analysis of Census 2001 data).

In terms of race, South Africa has long used four racial categories, which persist to the present. According to the 2001 census, 71.5% of the residents in our study area were black African; 16.0% coloured; and 11.7% white, with a very small remainder (less than 1%) were Asian/Indian. While there are also no specific quotas for racial representation, the high degree of salience of race, in the context of a mixed electoral system at the local level that combines

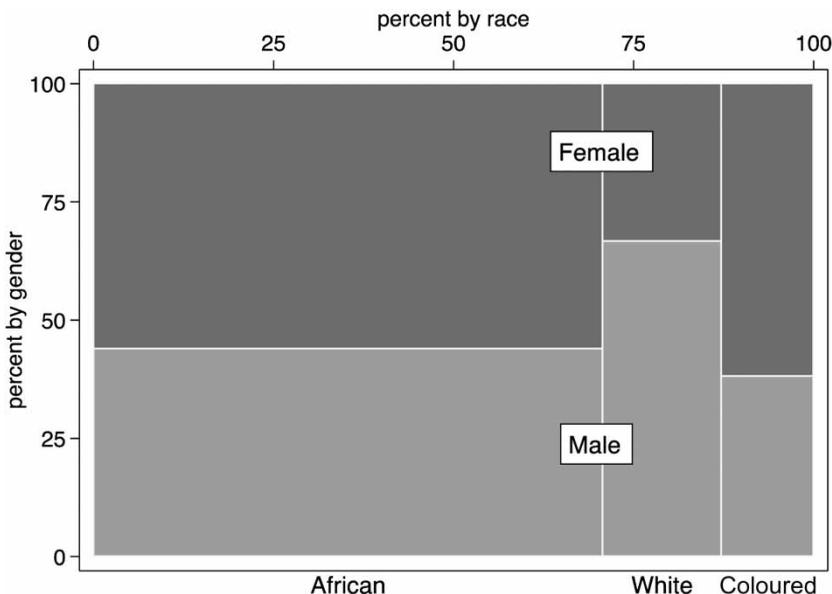


Figure 4. Race and gender composition of the local councillor survey.

proportional representation with single member wards (which themselves tend to be more racially homogeneous), has also led to strong descriptive representation. Within the sample, 69.9% of the councillors identified themselves as black African; 12.7% as coloured; and 16.3% as white.

Trying to understand the degree to which the race and gender of the councillors are actually associated with distinct policy preferences requires not only that I compare policy preferences across groups, but that I conduct 'fair' comparisons. For example, if the other characteristics of female councillors – for instance their age or level of education – are substantially different from those of their male counterparts, then gender group differences in policy preferences might reflect those other differences as much as they do the independent effect of gender. In some important ways, the South African case makes it quite difficult to establish such comparison, because the history of discrimination implies that the socio-economic circumstances of councillors varies substantially particularly by race group, and the internal composition of political parties are not reflective of the racial composition of the population more generally. A full 98% of the black African councillors were from the ANC party, while just 32% of the coloured and white councillors were from the ANC. Thus, it is extremely difficult to distinguish race from political party, which is a limitation of this study.

Other individual-level control variables, including level of education, age, extent of contact with external influences, personal experience with poverty, personal knowledge of someone who is HIV-positive, whether the councillor was elected to a ward (as compared with proportional representation) seat; and municipal-level characteristics, such as the racial fractionalization of the municipality and percent flush toilets are summarized in Table 1.

### *Analysis and discussion*

I calculate the extent of substantively distinctive representation by race and gender by comparing average differences in responses along gender lines (reported in Table 2) and along race lines (reported in Table 3). For these analyses, I have re-scaled all of the outcome variables to a 0–1 range to facilitate meaningful comparisons.

In the first row of each of those tables, I simply report the differences in means between the test and control groups for each of the policy preference variables. These results do not account for heterogeneity of characteristics within groups. Again, for example in the case of race, this simple comparison of mean scores (evaluated for statistical significance with a *t*-test) does not control for the fact that on average, black councillors have less education than coloured and white councillors. On the other hand, such differences are still substantively meaningful in highlighting the reality of average group differences. In other words, if it is the case that race or gender are associated with other characteristics, this is likely recognized by voters, which in turn facilitates their ability to predict the likely preferences of that councillor even with little additional information.

In each of Tables 2 and 3, in rows 2–4, I present estimates of between-group differences using 'nearest-neighbour matching' (Abadie *et al.* 2004).<sup>4</sup> More generally, this technique is used to facilitate analysis of nonrandomized experiments as if the treatments had been randomly assigned. As compared with a simple comparison of means, this technique identifies one or more well-matched control cases for each treated case, and calculates differences on the outcome (here responses to survey questions) between the groups, adjusting for other differences that occur within the respective groups.

In these analyses, this technique allows me to generate descriptive inferences about how certain characteristics are associated with key policy preferences, independent of other individual traits. For example, by comparing the responses of female councillors with those of male

Table 1. Descriptive statistics.

| Variable   | Source/description  | Obs. | Mean  | Std. dev. | Min.  | Max.  |
|--|---|------|-------|-----------|-------|-------|
| Female   | DSLCS 2009 (0/1)  | 166  | 0.530 | 0.501     | 0     | 1     |
| African  | DSLCS 2009 (0/1)  | 166  | 0.699 | 0.460     | 0     | 1     |
| Coloured   | DSLCS 2009 (0/1)  | 166  | 0.127 | 0.333     | 0     | 1     |
| White  | DSLCS 2009 (0/1)  | 166  | 0.163 | 0.370     | 0     | 1     |
| Risk HIV   | DSLCS 2009 (five-point scale)   | 162  | 0.840 | 0.202     | 0.25  | 1     |
| Risk TB  | DSLCS 2009 (five-point scale)   | 157  | 0.737 | 0.242     | 0     | 1     |
| AIDS priority  | DSLCS 2009 (0/1 – if mentioned as one top 3 ‘most important problems that you believe face people living in this municipality’)     | 166  | 0.139 | 0.347     | 0     | 1     |
| Support free ARVs  | DSLCS 2009 (four-point scale)   | 162  | 0.918 | 0.186     | 0     | 1     |
| Support mandatory HIV testing                                    | DSLCS 2009 (four-point scale)   | 160  | 0.700 | 0.337     | 0     | 1     |
| Support traditional medicine for AIDS                            | DSLCS 2009 (four-point scale)   | 163  | 0.648 | 0.346     | 0     | 1     |
| Support quarantine for people with XDR TB                        | DSLCS 2009 (four-point scale)   | 155  | 0.772 | 0.251     | 0     | 1     |
| Age  | DSLCS 2009 (1, 20–39; 2, 40–59; 3, 60+)   | 162  | 2.068 | 0.641     | 1     | 3     |
| Education  | DSLCS 2009 (2, not completed high school; 3, completed high school; 4, some university/college; 5, completed university/college)    | 163  | 3.479 | 1.119     | 2     | 5     |
| Personal knowledge of people who have died of AIDS last year     | DSLCS 2009 (0/1)  | 165  | 0.891 | 0.313     | 0     | 1     |
| Poverty index  | DSLCS 2009: three-point scale based on questions about personal experiences with hunger, informal housing, and lack of flush toilet | 165  | 1.782 | 1.143     | 0     | 3     |
| External influence   | DSLCS 2009: average level of influence of donors, experts, and civil society organizations, based on self-reported consultations    | 161  | 1.665 | 0.680     | 1     | 3     |
| Ward councillor  | DSLCS 2009 (0/1)  | 165  | 0.570 | 0.497     | 0     | 1     |
| Percent households with flush toilets in councillor constituency | Statistics South Africa 2009. For ward councillors, used wards; for PR councillors, used municipality                               | 164  | 0.491 | 0.322     | 0.001 | 0.995 |
| Race fractionalization 2001                                      | Statistics South Africa 2009 (author calculated Herfindahl index)   | 166  | 0.393 | 0.213     | 0.006 | 0.626 |

Note: DSLCS 2009: democracy in South Africa Local Councillor Study (author).

councillors who are otherwise extremely similar in many important respects, I am able to isolate the how gender is associated with councillor attitudes – which is the key concern for measuring the extent of substantive representation. To be clear, this is a descriptive analysis, and I am not attempting to make *causal* inferences about the effects of race or gender. In the second row of each table, I match on only a single trait – race in the case of the gender comparison and gender in the case of the race comparison. In the third row, I add a set of individual-level controls,

Table 2. Gender differences in AIDS policy preferences.

| Comparison: female vs. male           | HIV risk        | TB risk        | AIDS priority | Support free ARVs | Support mandatory HIV testing | Support traditional medicine for AIDS | Support XDR TB quarantine |
|---------------------------------------|-----------------|----------------|---------------|-------------------|-------------------------------|---------------------------------------|---------------------------|
| No controls ( <i>t</i> -test)         | 0.073** (0.031) | 0.065* (0.038) | 0.068 (0.054) | 0.031 (0.029)     | 0.115* (0.053)                | 0.080# (0.054)                        | 0.035 (0.040)             |
| NN matching on race                   | 0.070* (0.031)  | 0.070# (0.039) | 0.066 (0.053) | 0.025 (0.029)     | 0.091# (0.052)                | 0.047 (0.052)                         | 0.040 (0.040)             |
| NN matching on race, minimal controls | 0.062# (0.032)  | 0.069# (0.040) | 0.087 (0.056) | 0.028 (0.027)     | 0.075 (0.057)                 | 0.031 (0.054)                         | 0.069# (0.042)            |
| NN matching on race, many controls    | 0.071* (0.034)  | 0.084* (0.042) | 0.067 (0.058) | 0.028 (0.029)     | 0.080 (0.058)                 | 0.053 (0.053)                         | 0.059 (0.042)             |

Notes: NN, using 'nearest-neighbour' matching with inverse variance bias correction in rows 2–4. Size of standard errors is in parentheses. Minimal controls: age, poverty history, and ward councillor; many controls also include education, personal HIV, flush toilet share, and race fractionalization.

\* $p < 0.05$ .

\*\* $p < 0.01$ .

# $p < 0.10$ .

Table 3. Race differences in AIDS policy preferences.

| Comparison: black Africans vs. whites and coloureds | HIV risk       | TB risk         | AIDS priority  | Support free ARVs | Support mandatory HIV testing | Support traditional medicine for AIDS | Support XDR TB quarantine |
|---|----------------|-----------------|----------------|-------------------|-------------------------------|---------------------------------------|---------------------------|
| No controls ( <i>t</i> -test)                       | 0.041 (0.035)  | -0.041 (0.042)  | 0.084# (0.057) | 0.029 (0.031)     | 0.126* (0.056)                | 0.246** (0.000)                       | -0.105** (0.043)          |
| NN matching on gender                               | 0.030 (0.034)  | -0.057 (0.041)  | 0.080 (0.055)  | 0.024 (0.031)     | 0.116* (0.057)                | 0.228** (0.060)                       | -0.109** (0.040)          |
| NN matching on gender, minimal controls             | 0.046 (0.041)  | -0.094* (0.047) | 0.047 (0.066)  | 0.056 (0.035)     | 0.100 (0.069)                 | 0.128* (0.062)                        | -0.123** (0.043)          |
| NN matching on gender, many controls                | -0.006 (0.039) | -0.070 (0.049)  | 0.075 (0.069)  | 0.021 (0.036)     | 0.092 (0.074)                 | 0.174** (0.065)                       | -0.101* (0.049)           |

Notes: NN, using 'nearest-neighbour' matching with inverse variance bias correction in rows 2–4. Size of standard errors is in parentheses. Minimal controls: age, poverty history, and ward councillor; many controls also include education, personal HIV, flush toilet share, and race fractionalization.

\* $p < 0.05$ .

\*\* $p < 0.01$ .

# $p < 0.10$ .

including age, a measure of the councillor's personal experiences with poverty, and a dummy variable for whether the councillor is a ward councillor. Finally, in the fourth row, I also add controls for level of education, personal knowledge of someone who died of AIDS last year, the percentage of households in that councillor's constituency that have flush toilets, and the degree of racial heterogeneity or fractionalization of the municipality. In these analyses, analytic control is achieved through identification of control cases that are closest to the treatment case in terms of values on these other variables, and by weighting the results according to the quality of the matches.

The results demonstrate quite clearly a few gender- and race-based differences in councillor responses to the survey. However, the patterns are themselves quite distinctive across cleavages. Women clearly perceive the risks of HIV and TB as being more severe relative to their male counterparts; and despite the fact that inter-racial differences in HIV prevalence were orders of magnitude higher than with respect to gender, there were no statistically significant differences across race lines. And in the case of perceived TB risk, black African councillors actually reported lower levels of perceived risk than white and coloured councillors.

In terms of responses to the open-ended question about municipal priorities, both female and African councillors were more likely than men and whites/coloureds respectively to identify AIDS, but in neither case was this finding consistently robust at conventional levels of statistical significance.<sup>5</sup> There was also no substantial difference between groups in terms of support for the free provision of ARV drugs to people who are HIV-positive. In this case, there was so much consensus that this was a good policy idea among the entire sample of respondents that it was frankly implausible that I would find substantial differences in terms of race and/or gender. Nonetheless, it is worth reflecting that white and coloured councillors in this area could plausibly have opposed free provision, given that white and coloured constituents would be extremely unlikely to directly benefit, and yet, they supported this as a general policy.

In terms of other disease-related policy preferences, a few key findings stand out: first, preferences vary more widely along race lines than along gender lines. Quite clearly, black Africans are substantially *more* supportive of the proposal to provide free traditional remedies to people who are HIV-positive. In general, Africans disproportionately utilize traditional doctors and remedies, and this finding reflects this general tendency. Alternatively, Africans are much *less* supportive of quarantining individuals with multi-drug-resistant TB, which likely reflects both a concern that such a policy would more likely restrict the personal liberties of members of their group, and a general resistance to any form of incarceration, given the bitter history of detentions for black Africans in the country. That said, black Africans favour mandatory testing to a greater extent than councillors from other race groups, but with greater analytic control – matching on a larger number of covariates – the magnitude of differences shrinks, while the size of the standard error increases. Women are more supportive than are men of all of the policy proposals, but only in the case of support for mandatory HIV testing are the results sufficiently robust across (three of four) model estimates. This finding further highlights female councillors' distinctive concern for HIV status.

Are these patterns unique to HIV and AIDS? Or do they simply reflect more general differences in risk perceptions and policy preferences or even different styles of answering questions along gender and race lines? In Table 4, I report nearest-neighbour matching estimates of gender and race group comparisons for a wider range of questions about risk perception (murder, diarrheal disease, traffic accidents) and support for various policies (harsher prison terms, extending opportunities to people from historically disadvantaged groups, and allocating more resources to water delivery/quality). The findings of this analysis suggest that leader responses were specific to the particular issues and questions addressed on the survey. While it is true that female councillors generally reported higher perception of risks, this was not the case for traffic accidents,

Table 4. Gender and race effects on risk perception and policy preferences, not AIDS-related.

| Comparisons                                 | Risk murder    | Risk diarrheal disease     | Risk traffic accidents | Risk water shortage | Support harsher prison term | Support opportunity to historically disadvantaged | Support allocating more resources to water delivery |
|---|----------------|----------------------------|------------------------|---------------------|-----------------------------|---|---|
| Gender (NN matching on race, many controls) | 0.382* (0.182) | 0.331 <sup>#</sup> (0.176) | 0.020 (0.181)          | 0.345 (0.229)       | 0.037 (0.051)               | 0.186 (0.139)                                     | -0.005 (0.079)                                      |
| Race (NN matching on gender, many controls) | -0.170 (0.202) | -0.357 (0.223)             | -0.573** (0.214)       | -0.245 (0.268)      | 0.017 (0.064)               | 0.348* (0.172)                                    | 0.025 (0.101)                                       |

Note: NN, using 'nearest-neighbour' matching with inverse variance bias correction. Size of standard errors is in parentheses. Matching on: age, education, poverty history, ward councillor, flush toilet share, and race fractionalization.

\* $p < 0.05$ .

\*\* $p < 0.01$ .

<sup>#</sup> $p < 0.10$ .

and the differences were not statistically significant in the case of water shortages. Race proved to be a statistically significant predictor of perceived risk of traffic accidents (many fewer Africans drive relative to the size of their group as compared with whites), and perhaps not surprisingly, African councillors were more supportive of redistributive policies to historically disadvantaged groups – a phrase that generally connotes black African-oriented redistribution, but is sometimes used for gender- and class-based redistribution in the South African context. Despite wide variation in responses to the policy proposals in the sample, there was no systematic difference in support for the other policy proposals along race lines.

These findings suggest that there are indeed substantive implications for descriptive representation with respect to HIV and AIDS, at least from an attitudinal standpoint. I cannot, from this analysis alone, draw any conclusions about what councillors actually do within their constituencies, or whether the policies and practices of their respective councils would be different if they had been racially homogeneous or less gender-balanced in composition. But if we proceed with the assumption that at least to an extent, actions follow perceptions and preferences, there is good reason to believe that the high levels of descriptive representation in local government leads to the substantive representation of the diversity of views on infectious disease control, and may explain why some politicians appear to have more ‘political will’ on the issue than others.

### Conclusions and future research

This study sheds some important light on the nature of descriptive representation in the high HIV prevalence, heterogeneous democracy of South Africa. In line with knowledge that women tend to face greater personal danger from the epidemic, and shoulder the lion’s share of care giving for sick members of households and communities, I found that female councillors reported higher levels of perceived HIV and TB risk. But those differences did not translate into gender-specific preferences for action. Meanwhile, substantial differences across race lines in terms of what councillors believe ought to be *done* was not associated with differential risk perceptions across race groups, despite exponential differences in group HIV prevalence. To an extent, the null finding in terms of differences in risk perception across race groups is due to the fact that the vast majority of councillors perceive HIV to be a relatively high-risk problem in the areas they work. But the finding is also consistent with the proposition put forth in Lieberman (2009) that in the context of a stigmatized condition, there may be greater risk denial on the part of high prevalence race or ethnic groups, owing to perceived shame of association.

What are the substantive implications of such patterns of representation? This study suggests that at the very least, along the cleavages of race and gender, citizens’ diverse interests with respect to infectious disease are being expressed within local legislatures. And to the extent that good democratic governance requires full consideration of the needs and preferences of citizens, descriptive representation facilitates such outcomes. Citizens can find representation of at least some of their interests merely by electing leaders who, to an extent, look like themselves – whether they do this through direct elections, or through institutions such as those in South Africa, which have provided a high degree of descriptive representation. Through processes of deliberation, better policies may be enacted and implemented because democratic representatives have the opportunities to discuss and to engage a range of views.

On the other hand, the flip side of the representation of diverse interests is the heightened potential for conflict. A long line of scholarship has highlighted the pathologies associated with, for example, ethnic diversity when it comes to policy-making. Moreover, as Diamond (1990) has argued, one of the paradoxes of democracy is that the reconciliation of conflicting

interests can make governance difficult. Macro-level studies of AIDS policy-making have not found a strong association between level of democracy and quality of response, and it remains to be explored whether regimes characterized by a high degree of descriptive representation do better than those that lack such qualities.

To be certain, the empirical project presented here is a modest one, exploring the expressed preferences of just 166 local councillors in a single South African province. But it is the first systematic attempt to understand why elected local politicians might have different preferences concerning a leading source of mortality and morbidity. In so doing it provides additional evidence concerning the link between descriptive and substantive representation as well as useful insights about the attitudes of political leaders, which in other contexts have been treated rather ambiguously as instances of ‘political will’. The findings remind us that politicians do not simply act as free agents. In a democratic context, they also serve as representatives of various sub-groups within society. Future research will be needed to examine why some characteristics and not others serve as useful heuristics for representing citizen interests, and what exactly leads politicians to hold particular views. (For example, is it their shared experiences as members of a ‘group’? Calculations about what their group needs? Or perceptions of what their group wants?)

Given that South Africa remains the epicentre of the global AIDS pandemic and that local governments are increasingly being asked to do more suggests that the subject of analysis is substantively important. Moreover, given the extremely paltry base of knowledge, this work is necessary to establish a preliminary understanding of problem perception, prioritization, and attitudes toward related policies. To build on this, much larger samples of leaders from different places and with different responsibilities ought to be studied; other measures of policy preferences and behaviour need to be developed; and other research designs, including survey and field experiments, or even repeated surveys, are needed to better identify the determinants of what politicians think and what they do.

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### Notes

1. In general, the term ‘political will’ has not been well conceptualized or defined, but I assume that the term is used to connote an interest in how aggressively individual politicians respond to the policy issue of interest (infectious disease control). More recently, Post *et al.* (2010) and Fox *et al.* (2011) have offered useful discussions about how to define and analyse ‘political will’.
2. Discussed here as part of the AIDS epidemic because in sub-Saharan Africa, more than 70% of HIV-positive individuals are co-infected with TB and co-infection can accelerate disease progression and make treatment less effective (Bates *et al.* 2004, p. 271).
3. *Protection of human subjects*: because all respondents were publicly elected officials, who routinely speak about these questions in their work and for public audiences, Princeton University granted this project an exemption from full IRB review.
4. I obtain largely similar results using ordinary least squares, logit, and ordered logit estimation using the minimal controls specifications. However, given the relatively small sample size, the statistical significance of the estimates is more sensitive to alternate model specifications. Estimates of the effects of

gender are robust to inclusion of a dummy variable for ANC party membership. In the nearest neighbour matching estimates, no more than 25 observations were excluded owing to the absence of suitable matches.

5. Because this was a dichotomous outcome, in which a relatively small share of all respondents answered affirmatively, it stands to reason that these findings might have been statistically significant in a larger sample.

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